Letter to the editors

Synovial sarcoma

Mahendra BAGG, Hewavisenthi SJDeS

We appreciate the review article entitled "Ubiquitous Synovial Sarcoma" which highlights the occurrence of synovial sarcoma (SS) in almost all anatomical sites of the body. The article emphasizes the importance of including synovial sarcoma in the differential diagnosis of tumours that are located in unexpected sites. SS has been reported in almost every site in the body . We like to bring the attention of the editors to the fact that primary intraosseous SS has been reported in many skeletal sites including the tibia, sacrum, mandible, sternum and elbow (1). Therefore monophasic SS will be included in the differential diagnosis of intraosseous spindle cell lesions and the biphasic SS for biphasic intraosseous tumours such as metastatic deposits and adamantinoma of bone.

Heliwell et al has reported a case of biphasic SS in the small intestinal mesentery in 1995(2), which is another rare site for SS. This is important as SS can morphologically simulate gastrointestinal stromal tumour (GIST), which is a more frequently identified primary mesenteric tumour. Furthermore it had been reported that certain soft tissue sarcomas, such as SS and leiomyosarcomas that resemble GIST morphologically, stain positive for KIT (CD117) antigen (3). KIT antigen positiity is used not only as a prerequisite for the diagnosis of GIST, but also for the treatment eligibility for tyrosine kinase inhibitors. A similar treatment modality has been proposed for KIT positive SS (4). However there is a discrepancy in the literature with regard to the immunoreactivity of KIT in SS (3,5,6). The difference in the results of these studies could be due to variation in antibody used or variation in the immunohistochemical staining protocol (5,6). Since treatment eligibility for tyrosine kinase inhibitors such as Imitanib relies on the results of KIT immunostaining, it is critical to have standardized and reproducible results before imparting false hopes of treatment sensitivity to clinicians and patients.

References

1. Beck SE, Nielsen GP, Raskin KA, Schwab JH. Intraosseous synovial sarcoma of the proximal tibia. International Journal of Surgical Oncology doi: 10.1155/2011/184891.

2. Helliwell TR, King AP, Raraty M, Wittram C, Morris AI, Myint S et al Biphasic synovial sarcoma in the small intestinal mesentery. Cancer 1995; 75: 2862-6.

3. Sabah M, Leader M, Kay E. The problem with KIT: clinical implications and practical difficulties with CD117 immunostaining. Applied Immunohistochemistry and Molecular Morphology 2003; 11: 56-61.

Department of Pathology, Faculty of Medicine, University of Kelaniya, Sri lanka.
Correspondence: Mahendra BAGG, Department of Pathology, Faculty of Medicine, PO Box 6, Thalagolle Road, Ragama, Sri Lanka. e- mail: baggmahendra@yahoo.co.uk

4. López-Guerrero JA, Navarro S, Noguera R, Carda C, Fariñas SC, Pellín A et al. Mutational analysis of the c-KIT AND PDGFRalpha in a series of molecularly well-characterized synovial sarcomas. Diagnostic Molecular Pathology 2005; 14: 134-9.

5. Tamborini E, Papini D, Mezzelani A, Riva C, Azzarelli A, Sozzi G et al. c-KIT and c-KIT ligand (SCF) in synovial sarcoma (SS): an mRNA expression analysis in 23 cases. British Journal of Cancer 2001; 85: 405-11.

6. Hornick J L, Fletcher C D M: Immunohistochemical staining for KIT (CD117) in soft tissue sarcomas is very limited in distribution. American Journal of Clinical Pathology 2002; 117: 188-193.

Synovial sarcoma - Reply

The editors welcome the informative comment on the article entitled " The ubiqitous Synovial Sarcoma" which appeared in the Journal of Diagnostic Pathology 2006/07; 5: 11-15.